HOUSE No.4974

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, July 15, 2008.

The committee on Ways and Means, to whom was referred the Senate Bill to promote cost containment, transparency and efficiency in the delivery of quality health care (Senate, No. 2660), reports that the same ought to pass with an amendment by striking out all after the enacting clause and inserting in place thereof the text contained in House document numbered 4974.

For the committee,

ROBERT A. DeLEO.

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Text of an amendment recommended by the committee on Ways and Means to the Senate Bill to promote cost containment, transparency and efficiency in the delivery of quality health care (Senate, No. 2660). July 15, 2008.

The Commonwealth of Massachusetts

In the Year Two Thousand and Eight.

By striking out all after the enacting clause and inserting in place thereof the following:

"SECTION 1. Paragraph (d) of section 38C of chapter 3 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out the third sentence and inserting in place thereof the following sentence:- The division shall enter into interagency agreements as necessary with the office of Medicaid, the group insurance commission, the department of public health, the division of insurance, the health care quality and cost council, and other state agencies holding utilization, cost, or claims data relevant to the division's review under this section.

SECTION 2. Chapter 6A of the General Laws is hereby amended by striking out section 16K, as so appearing, and inserting in place thereof the following section:-

Section 16K. (a) There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health care by: (i) being a repository of health care quality and cost data for consumers, health care providers and insurers; (ii) disseminating health care quality and cost data to consumers, health care providers, and insurers via a consumer health information website pursuant to subsection (e) and (h); (iv) establishing quality improvement and cost containment goals pursuant to subsection (i); and (v) establishing transparency standards, quality performance benchmarks, and goals for statewide health information technology adoption for health care providers and insurers pursuant to subsection (j).

(b) The council shall consist 16 members and shall be comprised of: (i) 8 ex-officio members, including the secretary of health and human services, who shall serve as the chair, the secretary of administration and finance, the auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and

policy, the commissioner of public health, and the executive director of the group insurance commission, or their designees; and (ii) 8 representatives of nongovernmental organizations be appointed by the governor, including 1 representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 representative of the Massachusetts Association of Health Underwriters, Inc., 1 representative of the Massachusetts Medicaid Policy Institute, Inc., 1 expert in health care policy from a foundation or academic institution and 1 representative of a non-governmental purchaser of health insurance.

Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. The department shall provide administrative support to the council as requested.

(c) All meetings of the council shall be in compliance with chapter 30A, except that the council, through its bylaws, may provide for executive sessions of the council. No action of the council shall be taken in an executive session.

The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, appoint an executive director and employ such additional staff or consultants as it deems necessary.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

(d) The council shall be a repository of health care quality and cost data. The council shall disseminate this data to consumers, health care providers and insurers through: (i) a publicly accessible consumer health information website, (ii) reports on performance provided to health care providers and (iii) any other analysis and reporting the council deems appropriate.

When collecting data for the repository the council shall, to the extent possible, utilize existing public and private data sources and agency processes for data collection, analysis, and technical assistance. The council may enter into an interagency service agreement with the division of health care finance and policy for data collection analysis, and technical assistance.

The council may, subject to chapter 30B, contract with an independent health care organization for data collection, analysis, or technical assistance related to its duties; provided, however, that the organization has a history of demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to quality and cost across the health care system; (ii) identify, through data analysis, quality improvement areas; (iii) work with Medicare, MassHealth, and other insurers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; (v) establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii) identify and, when necessary, develop appropriate measures of quality and cost for public reporting of quality and cost information.

(e) The council shall, in consultation with the advisory committee established by section 16L, establish and maintain a consumer health information website. The website shall contain information comparing the quality and cost of health care services and may also contain general health care information as the council deems appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website.

The council shall, in consultation with its advisory committee, develop and adopt, on an annual basis, a reporting plan specifying the quality and cost measures to be included on the consumer health information website and the security measures used to maintain confidentiality and preserve the integrity of the data. In developing the reporting plan, the council, to the extent possible, shall collaborate with other organizations or state or federal agencies that develop, collect, and publicly report health care quality and cost measures and the council shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the council shall determine for each service the comparative information to be included on the

consumer health information website, including whether to: (i) list services separately or as part of a group of related services; and (ii) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the council shall state its reasons for the rejection. The reporting plan and any revisions adopted by the council shall be promulgated by the council. The council shall submit the reporting plan and any periodic revisions to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate.

The website shall provide updated information on a regular basis, at least annually, and additional comparative quality and cost information shall be published as determined by the council, in consultation with the advisory committee. To the extent possible, the website shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (ii) general information related to each service or category of service for which comparative information is provided; (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable events reported under section 51H of chapter 111.

(f) The council, through its rules and regulations, shall provide access to data it collects pursuant to this section under conditions that: (i) protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the release of data that could reasonably be expected to increase the cost of health care. The council may limit access to data based on its proposed use, the credentials of the requesting party, the type of data requested or other criteria required to make a determination regarding the appropriate release of the data. The council shall also limit the requesting party's use and release of any data to which that party has been given access by the council.

Data collected by the council under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise provided by the council.

The council shall, through interagency service agreements, allow the use of its data by other state agencies, including by the division of health care finance and policy for review and evaluation of mandated health benefit proposals as required by section 38C of chapter 3.

(h) The council, in consultation with its advisory committee, shall disseminate to health care providers their individualized de-identified data, including comparisons with other health care providers on the quality, cost and other data to be published on the consumer health information website.

(i) The council, in consultation with its advisory committee, shall develop annual health care quality improvement and cost containment goals using the data collected under subsection (d). For each goal, the council shall identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable to the health care providers, insurers, or the commonwealth, and estimate the expected improvements in the health status of health care consumers in the commonwealth. The council may recommend legislation or regulatory changes to achieve these goals.

(j) The council, in consultation with its advisory committee, relevant state agencies, and public and private health care organizations, shall develop and annually publish: (i) transparency standards, including, standardization of claims processing, common and consistent reporting of quality measures, common use of measures used for pay-for-performance reimbursement; (ii) quality performance benchmarks for health care providers and insurers that are clinically important, evidence-based, standardized, timely, include both process and outcome measures, and encourage health care providers and insurers to improve their quality of health. The benchmarks should be developed based on the work of national organizations, including the National Quality Forum and the Hospitals Quality Alliance, and (iii) goals for statewide adoption of health information technology certified by the certification commission for health care information technology.

(k) The council shall conduct annual public hearings at which health care providers, insurers, relevant state agencies, and public and private health care organizations shall report their progress towards achieving the quality improvement and cost containment goals, adopting the transparency standards and meeting the quality performance benchmarks. The council shall provide health care providers, insurers, state agencies and the general court with the following, at least 60 days prior to the public hearings: (i) recommended action required by each entity to

achieve the specified quality and cost containment goals; and (ii) recommendations for adoption of each transparency standard, quality performance benchmark, and health information technology adoption goal established by the council.

(l) The council shall file a report, not less than annually, with the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate on its progress in achieving the goals of improving quality and containing or reducing health care costs data provided pursuant to chapter 111N. The report shall include, at minimum, a review of the progress towards achieving the quality improvement and cost containment goals, adoption of transparency standards, meeting the quality performance benchmarks, and achieving the health information technology adoption goals.

The council shall provide its advisory committee with reasonable opportunity to review and comment on all reports before their public release.

Reports of the council shall be published on the consumer health information website.

SECTION 3. Chapter 6A of the General Laws is hereby amended by striking out section 16L, as amended by chapter 205 of the acts of 2007, and inserting in place thereof the following section:-

Section 16L. (a) There shall be established an advisory committee to the health care quality and cost council, established by section 16K, to allow the broadest possible involvement of the health care industry and others concerned about health care quality and cost.

(b) The advisory committee shall consist of at least 28 members to be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts AFL-CIO Council, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative of Health Care For All, Inc., 1 of whom shall be a representative of the Massachusetts Public Health Association, 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of

whom shall be a representative of the Massachusetts Extended Care Federation, Inc., 1 of whom shall be a representative of the Massachusetts Council of Human Service Providers, Inc., 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Associated Industries of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Business Roundtable, Inc., 1 of whom shall be a representative of the Massachusetts Taxpayers Foundation, 1 of whom shall be a representative of the Massachusetts chapter of the National Federation of Independent Business, 1 of whom shall be a representative of the Massachusetts Biotechnology Council, Inc., 1 of whom shall be a representative of the Blue Cross Blue Shield of Massachusetts Foundation, Inc., 1 of whom shall be a representative of the Massachusetts chapter of the American Association of Retired Persons, 1 of whom shall be a representative of the Massachusetts Coalition of Taft-Hartley Trust Funds, Inc., and additional members including, but are not limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary health care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession and a representative of the pharmaceutical field. Members of the advisory committee shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

(c) The members of the advisory committee shall annually elect a chair, vice chair, and secretary and may adopt by-laws governing the affairs of the advisory committee.

(d) The advisory committee shall have the following duties: (i) advise the council on the consumer health information website and health care provider and insurer reports; (ii) advise the council on the annual health care quality improvement and cost containment goals, transparency standards and quality performance benchmarks; and (iii) review and comment on all reports of the council before public release, including the annual reporting plan and any revisions and the annual report to the general court.

(e) A written record of all meetings of the committee shall be maintained by the secretary and a copy filed within 15 days after each meeting with the council.

SECTION 4. Chapter 40J of the General Laws is hereby amended by inserting after section 6C the following 2 sections:-

Section 6D. (a) There shall be established a health information technology advisory council within the corporation. The council shall advance the dissemination of health information technology across commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.

(b) The council shall consist of 11 members: 1 of whom shall be the secretary of health and human services, who shall serve as the chair; 1 of whom shall be the secretary of administration and finance, or a designee; 1 of whom shall be the house chairman of the joint committee on health care financing, or his designee; 1 of whom shall be the senate chair of the joint committee on health care financing, or his designee; 1 of whom shall be the house chair of the joint committee on economic development and emerging technologies, or his designees; 1 of whom shall be the senate chair of the joint committee on economic development and emerging technologies, or his designee; 1 of whom shall be the executive director of the health care quality and cost council; 2 of whom shall be appointed by the governor and shall be health information technology experts; 1 of whom shall be appointed by the speaker of the house of representatives who shall be an expert in the areas of law and health policy, and 1 of whom shall be appointed by the president of the senate who shall be an expert in the areas of law and health policy . Members of the council shall be appointed for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

The members of the advisory council shall be deemed to be directors for purposes of the fourth paragraph of section 3; provided that, notwithstanding the provisions of said section 3 and sections 5, 6 and 7 of chapter 268A, no member of the advisory council shall be precluded from participating in matters before the council because he, or a related party within the scope of section 6 of said chapter 268A, has a financial interest in a matter being considered by the council, if such interest or involvement was disclosed in advance to the advisory council and recorded in the minutes of the advisory council's proceedings; and provided further, that no member shall be deemed to violate section 4 of said chapter 268A because of his receipt of his usual and regular compensation from his employer during the time in which the member participates in the activities of the advisory council.

(c) The council shall advance the dissemination of health information technology by: (i) facilitating the implementation and use of electronic health records systems by health care providers in order to improve health care delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease management initiatives, and establish transparency; (ii) facilitating the creation and maintenance of a statewide interoperable electronic health records network that allows individual health care providers in all health care settings to exchange patient health information with other providers; and (iii) identifying and promoting an accelerated dissemination in the commonwealth of emerging health care technologies that have been developed and employed and that are expected to improve health care quality and lower health care costs, but that have not been widely implemented in the commonwealth.

(d) The council shall develop community-based implementation plans that assess a municipality's or region's readiness to implement and use electronic health record systems and an interoperable electronic health records network within the referral market for a defined patient population.

Each implementation plan shall address the development, implementation and dissemination of electronic health records systems among health care providers in the community, particularly providers, such as community health centers, who serve underserved populations, including, but not limited to, racial, ethnic and linguistic minorities, uninsured persons, and areas with a high proportion of public payer care.

Each implementation plan shall: (i) allow seamless, secure electronic exchange of health information among health care providers, health plans, and other authorized users; (ii) provide consumers with secure, electronic access to their own health information; (iii) meet all applicable federal and state privacy and security requirements, including requirements imposed by 45 CFR §§160, 162, 164; (iv) meet standards for interoperability adopted by the council; (v) give patients the option of allowing only designated health care providers to disseminate their individually identifiable information; (vi) provide public health reporting capability as required under state law; and (vii) allow reporting of health information other than identifiable patient health information for purposes of such activities as the secretary of health and human services may from time to time consider necessary.

(e) The corporation shall contract with organizations that have a proven history of success in implementing electronic health records and

health information technology programs, including vendor selection, practice workflow design, hardware and software implementation, training, and support. These implementation organizations shall: (i) facilitate a public-private partnership that includes representation from hospitals, physicians and other health care professionals, health insurers, employers, and other health care purchasers, health data and service organizations, and consumer organizations; (ii) provide resources and support to recipients of grants awarded under subsection (f) to implement each program within the designated community pursuant to the implementation plan; (iii) certify and disburse funds to subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice redesign, adoption of electronic health records, and utilization of care management strategies; (v) ensure that electronic health records systems are fully interoperable and secure and that sensitive patient information is kept confidential by exclusively utilizing electronic health records products that are certified by the Certification Commission for Health Information Technology; and (vi) work with the council to certify a group of subcontractors who will provide the necessary hardware and software for system implementation.

(f) Funding for the council's activities shall be through the Health Information Technology Fund, established in section 6E. The council shall develop mechanisms for funding health information technology, including a grant program to assist health care providers with costs associated with health information technologies, including electronic health records systems, and coordinated with other electronic health records projects seeking federal reimbursement.

All grants shall be approved by the council, which shall work with the implementation organization to oversee the grant-making process. The council shall allow the use of financial participation of the grantee and any other factors it deems relevant as a condition for awarding grants. Each recipient of monies from this program shall: (i) capture and report certain quality improvement data, as determined by the council in consultation with the health care quality and cost council; (ii) implement the system fully, including all clinical features, no later than the second year of the grant; and (iii) make use of the system's full range of features.

Applications for funding shall be in the form and manner determined by the corporation, and shall include the information and assurances required by the corporation.

(g) The council shall receive staff assistance from the corporation and may employ such additional staff or consultants as it deems necessary.

(h) The council shall file an annual report, no later than January 30, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, and the house and senate committees on ways and means concerning the activities of the council in general and, in particular, describing the progress to date in implementing a statewide electronic health records system and recommending such further legislative action as it deems appropriate.

Section 6E. There shall be established and set up on the books of the corporation the Health Information Technology Fund, hereinafter referred to as "the fund," for the purpose of supporting the advancement of health information technology in the commonwealth including, but not limited to, the full deployment of electronic health records. There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized by the general court and designated thereto; any federal grants or loans; and any private gifts, grants, or donations made available. The corporation shall hold the fund in an account or accounts separate from other funds. The fund shall be administered by the executive director of the Massachusetts Technology Park Corporation without further appropriation, provided that any disbursement or expenditure of funds shall be approved by the health information technology advisory council established under section 6D. Amounts credited to the fund shall be available for expenditures on the grant program established in said section 6D and for other forms of financial assistance that the advisory council determines are necessary to support the dissemination and development of health information technology in the commonwealth. The executive director of the corporation shall seek, to the greatest extent possible, private gifts, grants, and donations to the fund.

SECTION 5. Chapter 111 of the General Laws is hereby amended by inserting after section 4M the following section:—

Section 4N. (a) The department shall, in cooperation with Commonwealth Medicine at the University of Massachusetts medical school, develop, implement and promote an evidence-based outreach and education program about the therapeutic and cost-effective utilization of prescription drugs for physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs. In

developing the program, the department shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the University of Massachusetts medical school.

(b) The program shall provide for physicians, pharmacists and nurses under contract with the department to conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing methods from behavioral science, educational theory and, where appropriate, pharmaceutical industry data and outreach techniques; provided, however, that to the extent possible, the program shall inform prescribers about drug marketing that is intended to circumvent competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options.

The program shall include outreach to physicians and other health care practitioners who participate in MassHealth, the subsidized catastrophic prescription drug insurance program authorized in section 39 of chapter 19A, the commonwealth care health insurance program, to other publicly-funded, contracted or subsidized health care programs, to academic medical centers and to other prescribers.

The department shall, to the extent possible, utilize or incorporate into its program other independent educational resources or models proven effective in promoting high quality, evidenced-based, cost-effective information regarding the effectiveness and safety of prescription drugs, including, but not limited to: (i) the Pennsylvania PACE/Harvard University Independent Drug Information Service; (ii) the Academic Detailing Program of the University of Vermont College of Medicine Area Health Education Centers; (iii) the Oregon Health and Science University Evidence-based Practice Center's Drug Effectiveness Review project; and (iv) the North Carolina evidence-based peer-to-peer education program outreach program.

(c) The department may establish and collect fees for subscriptions and contracts with private payers. The department may seek funding from nongovernmental health access foundations and undesignated drug litigation settlement funds associated with pharmaceutical marketing and pricing practices.

SECTION 6. Said chapter 111 is hereby further amended by inserting after section 25K the following 3 sections:—

Section 25L. (a) There shall be in the department a health care workforce center to improve access to health care services. The center, in

consultation with the health care workforce advisory council established by section 25M and the commissioner of labor and workforce development, shall: (i) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention; (ii) monitor trends in access to primary care and physician subspecialties and nursing services, through activities including: (1) review of existing data and collection of new data as needed to assess the capacity of the health care workforce to serve patients, including patient access and regional disparities in access to physicians or nurses and to examine physician and nursing satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians and nurses; (3) make projections on the ability of the workforce to meet the needs of patients over time; identify strategies currently being employed to address workforce needs, shortages, recruitment and retention; study the capacity of public and private medical schools in Massachusetts to expand the supply of primary care physicians; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforces shortages through the following activities, including: (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians and nurses.

(c) The center shall maintain ongoing communication and coordination with the health care quality and cost council, established by section 16K of chapter 6A, and the health disparities council, established by section 16O of said chapter 6A.

(d) The center shall annually submit a report, no later than March 1, to the governor; the health care quality and cost council established by section 16K of chapter 6A, the health disparities council established by

section 16O of chapter 6A; and the general court, by filing the report with the clerk of the house of representatives, the clerk of the senate, the joint committee on labor and workforce development, the joint committee on health care financing, and the joint committee on public health. The report shall include: (i) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, and nurses, (ii) data on factors influencing recruitment and retention of physicians and nurses, (iii) short and long-term projections of physician and nurse supply and demand, (iv) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention, (v) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention, (vi) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention.

Section 25M. (a) There shall be a healthcare workforce advisory council within, but not subject to the control of, the health care workforce center established by section 25L. The council shall advise the center on the capacity of the healthcare workforce to provide timely, effective, culturally competent, quality physician and nursing services.

(b) The council shall consist of 14 members who shall be appointed by the governor: 1 of whom shall be a physician with a primary care specialty designation who practices in a rural area; 1 of whom shall be a physician with a primary care specialty who practices in an urban area; 1 of whom shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse, authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall be an advanced practice nurse, authorized under section 80B of said chapter 112, who practices in an urban area; 1 of whom shall be a registered nurse, registered under section 74 of said chapter 112; 1 of whom shall be a representative of the Massachusetts Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; the Massachusetts Center for Nursing, Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of Health Care For All, Inc. Members of the council shall be appointed for terms of 3 years or until a successor

is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate appointing authority.

The members of the council shall annually elect a chair, vice chair, and secretary and may adopt by-laws governing the affairs of the council.

The council shall meet at least bimonthly, at other times as determined by its rules, and when requested by any 8 members.

(c) The council shall advise the center on: (i) trends in access to primary care and physician subspecialties and nursing services; (ii) the development and administration of the loan repayment program, established under section 25N, including criteria to identify underserved areas in the commonwealth; (iii) solutions to address identified health care workforces shortages; and (iv) the center's annual report to the general court.

Section 25N. (a) There shall be a physician loan repayment program, administered by the health care workforce center established by section 25L. The program shall provide repayment assistance for medical school loans to participants who: (i) are graduates of medical schools; (ii) specialize in family medicine, internal medicine, pediatrics, or obstetrics/gynecology; (iii) commit to providing those specialties in medically underserved areas for a minimum of 2 years; (iv) demonstrate competency in health information technology including, use of electronic medical records, computerized physician order entry and e-prescribing; and (v) meet other eligibility criteria, including service requirements, established by the board.

(b) The center shall promulgate regulations for the administration and enforcement of this section which shall include penalties and repayment procedures if a participant fails to comply with the program's requirements.

The center shall, in consultation with the health care workforce advisory council and the public health council, establish criteria to identify medically underserved areas within the commonwealth. These criteria shall consist of quantifiable measures, which may include the availability of primary care medical services within reasonable traveling distance, poverty levels, and disparities in health care access or health outcomes.

(c) The center shall evaluate the program annually, including exit interviews of participants to determine their post-program service plans and to solicit program improvement recommendations.

(d) The center shall, not later than July 1, file an annual report with the governor, the clerk of the house of representatives, the clerk of the senate, the house committee on ways and means, the senate committee ways and means, the joint committee on health care financing, and the joint committee on public health. The report shall include annual data and historical trends of: (i) the number of applicants, the number accepted, and the number of participants by race, gender, medical specialty, medical school, residence prior to medical school, and where they plan to practice after program completion; (ii) the service placement locations and length of service commitments by participants; (iii) the number of participants who fail to fulfill the program requirements and the reason for the failure; (iv) the number of former participants who continue to serve in underserved areas; and (v) program expenditures.

SECTION 7. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Facility", a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.

"Healthcare-associated infection", a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.

"Serious reportable event", an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.

(b) A facility shall report data and information about healthcare-associated infections and serious reportable events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established

by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.

(c) The department shall, through interagency service agreements, transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.

SECTION 8. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Facility", a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.

"Healthcare-associated infection", a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.

"Serious adverse drug event", any preventable event that causes inappropriate medication use in a hospital or ambulatory surgical center that leads to harm to a patient, as further defined in regulations of the department.

"Serious reportable event", an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.

(b) A facility shall report data and information about healthcare-associated infections, serious reportable events, and serious adverse drug events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The

department may require facilities to register in and report to nationally recognized quality and safety organizations.

(c) The department, through interagency service agreements, shall transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.

SECTION 9. Said chapter 111 is hereby further amended by inserting after section 53D the following 3 sections:-

Section 53E. The department shall promulgate regulations for the establishment of a patient and family advisory council at each hospital in the commonwealth. The council shall advise the hospital on matters including, but not limited to, patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters. Members of a council may act as reviewers of publicly reported quality information, members of task forces, members of awards committees for patient safety activities, members of advisory boards, participants on search committees and in the hiring of new staff, and may act as co-trainers for clinical and nonclinical staff, in-service programs, and health professional trainees or as participants in reward and recognition programs.

Section 53F. The department shall require acute care hospitals to have a suitable method for health care staff members, patients and families to request additional assistance directly from a specially-trained individual if the patient's condition appears to be deteriorating. The acute care hospital shall have an early recognition and response method most suitable for the hospital's needs and resources, such as a rapid response team. The method shall be available 24 hours per day.

Section 53G. Any entity that is certified or seeking certification as an Ambulatory Surgical Center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the

American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department of public health determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need for such a facility. For purposes of this section, "clinic" shall not include a clinic conducted by a hospital licensed under said section 51 or by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 10. The first paragraph of section 70 of said chapter 111 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following 4 sentences:- These records may be handwritten, printed, typed or in electronic digital media or converted to electronic digital media as originally created by such hospital or clinic, by the photographic or microphotographic process, or any combination thereof. The hospital or clinic may destroy records only after the applicable retention period has elapsed and after notifying the department of public health, in accordance with its regulations, that the records will be destroyed. The department, through its regulations, shall establish an appropriate notification process. On the notice of privacy practices distributed to its patients, a hospital or clinic shall provide: (i) information concerning the provisions of this section and (ii) the hospital or clinic's records termination policy.

SECTION 11. Said section 70 of said chapter 111 of the General Law, as so appearing, is hereby further amended by striking out, in line 66, the word "thirty" and inserting in place thereof the following figure:- 20

SECTION 12. The General Laws are hereby amended by inserting after chapter 111M the following chapter:-

CHAPTER 111N

PHARMACEUTICAL AND MEDICAL DEVICE MANUFACTURER CONDUCT

Section 1. As used in this chapter the following terms shall, unless the context clearly requires otherwise, have the following meanings:-

"Department", the department of public health.

"Drug" or "medicine",(i) articles recognized in the official United States Pharmacopoeia, the official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (ii) articles and devices intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; (iii) articles, other than food, aspirin and effervescent saline analgesics, intended to affect the structure or any function of the body of man or other animals; (v) articles intended for use as a component of any article specified in clause (i), (ii) or (iii);or any controlled substance.

"Manufacturer", a person who: (i) derives, produces, prepares, compounds, mixes, cultivates, grows or processes any drug or medicine; (ii) repackages any drug or medicine for the purposes of resale; or (iii) produces or makes any devices or appliances that are restricted by federal law to sale by or on the order of a physician.

"Wholesaler", a wholesale distributor who supplies or distributes drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician to a person other than the consumer or patient, including a person who derives, produces, prepares or repackages drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician on sales orders for resale; but not including a nonprofit cooperative agricultural organization which supplies or distributes veterinary drugs and medicines only to its own members.

Section 2. (a) A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall adopt a written marketing code of conduct establishing the practices and standards that govern the marketing and sale of its products. The marketing code of conduct shall be based on applicable legal standards and incorporate principles of health care including, without limitation, requirements that the activities of the wholesaler or manufacturer be intended to benefit patients, enhance the practice of medicine and not interfere with the independent judgment of health care professionals. Adoption of the most recent version of the Code on Interactions with Healthcare Professionals developed by the Pharmaceutical Research and Manufacturers of America satisfies the requirements of this subsection.

(b) A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall adopt a training program to provide regular training

to appropriate employees including, without limitation, all sales and marketing staff, on the marketing code of conduct.

(c) A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall conduct annual audits to monitor compliance with the marketing code of conduct.

(d) A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall adopt policies and procedures for investigating instances of noncompliance with the marketing code of conduct including, without limitation, the maintenance of effective lines of communication for employees to report noncompliance, the investigation of reports of noncompliance, the taking of corrective action in response to noncompliance and the reporting of instances of noncompliance to law enforcement authorities in appropriate circumstances.

(e) A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall identify a compliance officer responsible for developing, operating and monitoring the marketing code of conduct.

Section 3. A wholesaler or manufacturer who employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall annually submit to the department:(i) a copy of its marketing code of conduct; (ii) a description of its training program; (iii) a description of its investigation policies; (iv) the name, title, address, telephone number and electronic mail address of its compliance officer; and (v) certification that it has conducted its annual audit and is in compliance with its marketing code of conduct.

Section 4. On or before January 15 of each odd-numbered year, the department shall prepare and submit to the governor, and to the chairs of the joint committee on health care financing and the chairs of the house and senate committee on ways and means, a compilation of the information submitted to the department pursuant to section 3, other than any information identified as a trade secret in the information submitted to the department.

Section 5. The department shall determine the manner and form of the submissions required under section 3 and shall define compliance for the purposes of this chapter. The department shall not require the disclosure of the results of an audit conducted pursuant to subsection (c) of section 2. The department shall publish on its website information concerning the compliance of all wholesalers and manufacturers with the

requirements of this chapter. The department shall not disclose any proprietary or confidential business information that it receives pursuant to this section.

Section 6. The department shall promulgate rules and regulations for the administration and enforcement of this chapter.

SECTION 13. Section 2 of chapter 112 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting at the end thereof the following sentence:- The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board.

SECTION 14. Section 9E of said chapter 112 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the word "two" and inserting in place thereof the following figure:- 4

SECTION 15. Said chapter 112 of the General Laws is hereby amended by inserting after section 39C the following 2 sections:-

Section 39D. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; or an organization entering into a preferred provider arrangement under chapter 176I.

"Administrator", any person who receives or collects charges, contributions or premiums for, or adjusts or settles claims in connection with, any type of health benefit provided under the plan as an alternative to insurance.

"Commercial purpose", advertising, marketing, promotion, or any similar activity that is used or intended to be used to influence sales or the market share of a pharmaceutical drug, to influence or elevate the prescribing behavior of a prescriber, market prescription drugs to individuals or to elevate the effectiveness of a professional pharmaceutical detailing sales force.

"Identifying information", information that can be used to directly or indirectly identify the individual or the prescriber, including a person's name, address, telephone number, facsimile number, electronic mail address, photograph or likeness, account, credit card, medical record, social security number, or any other unique number, characteristic, code or information which is likely to lead to the identification of the individual or prescriber.

"Electronic transmission intermediary", an entity that provides the infrastructure that connects the computer systems or other electronic devices used by health care practitioners, prescribers, pharmacies, health care facilities and pharmacy benefit managers, carriers, administrators and agents and contractors of those persons and entities in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment or other prescription drug information.

"Health care facility", a licensed facility, institution or entity licensed that offers health care to persons in the commonwealth, including a health care provider, home health care provider, hospice program and a pharmacy.

"Health care practitioner", a person licensed to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals.

"Health plan", a health plan providing prescription drug coverage as authorized under the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173.

"Individual", a natural person who is the subject of prescription drug information.

"Pharmacy", any retail drug business registered by the board of registration in pharmacy in accordance with section 39 of chapter 112 that is authorized to dispense controlled substances, including a retail drug businesses as defined in section 1 of chapter 94C and a mail order pharmacy.

"Pharmacy benefits manager", an entity that performs pharmacy benefits management. "Pharmacy benefits manager" includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity and includes mail service pharmacy.

"Prescriber", a person who is licensed, registered or otherwise authorized to prescribe and administer drugs in the course of professional practice.

"Prescription drug information", information concerning a prescription drug that: (i) is required under federal law to be labeled "Caution: Federal law prohibits dispensing without prescription" prior to being dispensed or delivered, (ii) is required by an applicable federal or state law or rule to be dispensed on prescription only, or (iii) is restricted to use by practitioners only; including the lawful written or oral order of a practitioner for a drug or device, issued on a prescription form or by electronic transmission.

"Prescription drug information intermediary", a person or entity that communicates, facilitates or participates in the exchange of prescription drug information regarding an individual or a prescriber, including, but shall not limited to, a pharmacy benefits manager, a health plan, an administrator and an electronic transmission intermediary.

"Regulated transaction", a prescription for a drug that is written by a prescriber within the commonwealth or that is dispensed within the commonwealth.

(b) A prescriber, carrier, pharmacy, or prescription drug information intermediary shall not license, use, sell, transfer or exchange for value, for any commercial purpose, prescription drug information related to a regulated transaction that has identifying information, except for: (i) the transfer of prescription drug information, including identification of the individual and prescriber, as required under the chapter 94C; (ii) the dispensing of prescription drugs to an individual or the individual's authorized representative, the transmission of prescription drug information between a prescriber and a pharmacy or other health care practitioner caring for the individual and the transfer of prescription information between pharmacies; (iii) the transfer of prescription records that may occur when a pharmacy's ownership is changed or transferred; (iv) care management educational communications provided to an individual about the individual's health condition, adherence to a prescribed course of therapy or other information relating to the drug being dispensed, treatment options or clinical trials; (v) transfers for the limited purpose of pharmacy reimbursement, prescription drug formulary or prior authorization compliance, patient care management, utilization review, health care research or as required by law; and (vi) the collection, use, transfer or

sale of prescription drug information that is de-identified and that does not directly or indirectly identify the individual or prescriber.

(c) A violation of this section shall be an unfair or deceptive act or practice in the conduct of trade in violation of section 2 of chapter 93A. Any person whose rights under this section have been violated may institute and prosecute in his own name and on his own behalf, or the attorney general, acting on behalf of the commonwealth, may institute a civil action for injunctive and other equitable relief.

Section 39E. Stores or pharmacies engaged in the drug business, as defined in section 37, shall inform the department of public health of any improper dispensing of prescription drugs that results in serious injury or death, as defined by the department in regulations, as soon as is reasonably and practically possible, but not later than 15 working days after discovery of the improper dispensing. The department of public health shall promulgate regulations for the administration and enforcement of this section.

SECTION 16. Said chapter 118E is hereby further amended by adding the following section:-

Section 55. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, the executive office of health and human services and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act compliant code sets as adopted by the Centers for Medicare and Medicaid Services: the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. The executive office and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.

(b) Subject to subsection (c), the executive office and its subcontractors shall, without local customization, use the standardized

claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the federal Health Insurance Portability and Accountability Act. The executive office and its subcontractors shall, without local customization, adopt and routinely process all changes to such formats which shall be effective on the same date as the implementation date established by the entity implementing the formats.

(c) Except for the requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede the executive office's or its subcontractor's payment policy or utilization review policy. Nothing in this section shall preclude the executive office or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies or provider contracts.

(d) The executive office and its subcontractors shall accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to this section.

SECTION 17. Section 55 of chapter 118E of the General Laws, inserted by section 16, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) The executive office and its subcontractors shall accept and recognize all claims submitted by health care providers pursuant to this section.

SECTION 18. Section 1 of chapter 118G of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting after the definition of "Pediatric specialty unit" the following definition:-

"Private health care payer", a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, or a health maintenance organization licensed under chapter 176G.

SECTION 19. Said section 1 of said chapter 118G of the General Laws, as so appearing, is hereby further amended by inserting after the definition of "Provider" the following definition:-

"Public health care payer", the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the commonwealth health insurance connector to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the commonwealth care health insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 20. Section 2 of said chapter 118G of the General Laws, as so appearing, is hereby amended by striking the second paragraph and inserting in place thereof the following paragraph:-

The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish such subdivisions within the division as the commissioner deems appropriate from time to time to fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the formulation of health care policy and in the provision and purchase of health care services; (ii) to work with other state agencies including, but not limited to, the departments of public health and mental health, the health care quality and cost council and the divisions of medical assistance and insurance to collect and publish data concerning the cost of health insurance in the commonwealth and the health status of individuals; (iii) to hold annual hearings concerning health care provider and payer costs and cost trends, and to provide an analysis of health care spending trends with recommendations for strategies to promote an efficient health delivery system; and (iv) to administer the health safety net office and trust fund established under sections 35 and 36 of this chapter.

SECTION 21. Section 6 of said chapter 118G of the General Laws, as so appearing, is hereby amended by striking the third paragraph and inserting in place thereof the following 4 paragraphs:-

The division may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers that enables the division to analyze: (i) changes over time in health insurance premium levels, (ii) changes in the benefit and cost-

sharing design of plans offered by these payers, and (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers.

The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, without limitation: (i) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan; (v) information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels.

The division shall require the submission of data and other information from public health care payers including, without limitation: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid.

The division shall, before adopting regulations under this section, consult with other agencies of the commonwealth and the federal government, affected providers, and affected payers, as applicable, to ensure that the reporting requirements imposed under the regulations are not duplicative or excessive. If reporting requirements imposed by the division result in additional costs for the reporting providers, these costs

may be included in any rates promulgated by the division for these providers. The division may specify categories of information which may be furnished under an assurance of confidentiality to the provider; provided that such assurance shall only be furnished if the information is not to be used for setting rates.

SECTION 22. Chapter 118G of the General Laws is hereby amended by inserting after section 6 the following section:—

Section 6½. (a) The division shall hold annual public hearings based on the information submitted under section 6 and 6A concerning health care provider and private and public health care payer costs and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premiums.

(b) Hearings shall be held by the commissioner or a designee, or a hearings officer, if authorized by the commissioner. Public notice of any hearing shall be provided at least 60 days in advance.

(c) The division shall, 30 days before the date of any hearing, publish a preliminary report of its findings based on information provided under section 6. The division may contract with an outside organization with expertise in issues related to the topics of the hearings to produce this preliminary report. The division shall use this preliminary report as a basis for designing the format and content of the hearing.

(d) The division shall identify as potential witnesses at the public hearing a representative sample of providers and payers, including (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest percent of gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (vii) any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program; (viii) the group insurance commission; and (ix) at least 3 municipalities that have adopted chapter 32B.

(e) Witnesses shall provide testimony at the public hearing in a manner and form to be determined by the division, including without limitation: (i) in the case of providers, testimony concerning payment systems, payer mix, cost structures, administrative and labor costs, capital and technology costs, adequacy of public payer reimbursement levels, reserve levels, utilization trends, and cost-containment strategies, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system, efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design and payment policies that enhance product affordability and encourage efficient use of health resources and technology, efforts by the payer to increase consumer access to health care information, and efforts by the payer to promote the standardization of administrative practices, and any other matters as determined by the division.

(f) The division shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the division's analysis of information provided at the hearings by providers and insurers, data collected by the division under sections 6 and 6A of this chapter, and any other information the division considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the division. The division shall consult with the health care quality and cost council when developing any measures or criteria to be used in its analysis. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public no later than December 31st.

SECTION 23. Section 36 of chapter 123 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting at the end thereof the following 4 sentences:- Each facility, subject to this chapter and section 19 of chapter 19, that provides mental health care and treatment shall maintain patient records, as defined in the first paragraph of section 70 of chapter 111, for at least 20 years after the closing of the record due to discharge, death or last date of service. A facility shall not destroy such records until after the retention period has

elapsed and only upon notifying the department of public health that the records will be destroyed, provided that the department shall promulgate regulations further defining an appropriate notification process. On the notice of privacy practices distributed to its patients, each facility shall provide: (i) information concerning the provisions of this section and (ii) the hospital or clinic's records termination policy

SECTION 24. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following 2 sections:-

Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, a carrier and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with the current Health Insurance Portability and Accountability Act compliant code sets: the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. A carrier and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.

(b) Subject to subsection (c), a carrier and its subcontractors shall, without local customization, use the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the Health Insurance Portability and Accountability Act. A carrier and its subcontractors shall, without local customization, adopt and routinely process all changes to such formats which shall be effective on the same date as the implementation date established by the entity implementing the formats.

(c) Except for the requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede a carrier's or its subcontractor's payment policy, utilization review policy or benefits under a health benefit plan. Nothing in this section shall

further preclude a carrier or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies, provider contracts or health benefit plans.

(d) Carriers and subcontractors thereof shall accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to this section.

Section 5B. To ensure uniformity and consistency in the submission and processing of claims for health care services pursuant to section 5A, the bureau of managed care within the division of insurance, after consultation with a statewide advisory committee including, but not limited to, representatives of the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a representative of a MassHealth contracted managed care organization, the executive office of health and human services, the division of health care finance and policy, the health care quality and cost council, the house of representatives and the senate, shall adopt policies and procedures to enforce said section 5A. The policies and procedures shall include a system for reporting inconsistencies related to a carrier's compliance with said section 5A. The bureau shall work jointly with the executive office of health and human services to resolve reports of noncompliance with the requirements of section 61 of chapter 118E. The bureau shall convene the advisory committee annually to review and discuss issues reported by health care providers pursuant to this section and to discuss further recommendations to improve the uniformity and consistency of the reporting of patient diagnostic information and patient care service and procedure information as it relates to the submission and processing of health care claims.

SECTION 25. Section 5A of said chapter 176O of the General Laws, as inserted by section 25, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) Carriers and their subcontractors shall accept and recognize all claims submitted by health care providers pursuant to this section.

SECTION 26. The General Laws are hereby amended by inserting after chapter 176Q the following chapter:—

CHAPTER 176R

CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program, except as otherwise prohibited by state or federal law or regulation.

"Commissioner", the commissioner of insurance.

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

"Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

"Nurse practitioner", a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under section 80B of chapter 112 and regulations promulgated thereunder.

"Participating provider", a provider who, has entered into an agreement, either directly or through a person or entity acting on the provider’s behalf, with a carrier or with its contractor or subcontractor, to provide health care services to an insured with an expectation of

receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the carrier.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care within the scope of practice.

Section 2. The commissioner and the group insurance commission shall require that all carriers recognize nurse practitioners as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by nurse practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth. This coverage shall be subject to the terms of a negotiated agreement between a carrier and a nurse practitioner.

Section 3. A participating nurse practitioner practicing within the scope of license, including all regulations requiring collaboration with a physician under section 80B of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured; provided, however, that nothing in this section shall require a carrier to accept new nurse practitioners in its networks if the carrier has determined that is has a sufficient number of nurse practitioners in its networks to meet its network adequacy requirements.

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide it's insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change its primary care provider to a participating provider nurse practitioner at any time during their coverage period.

Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that all participating provider nurse practitioners are included on any publicly accessible list of participating providers for the carrier.

Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations for the administration and enforcement of this chapter.

SECTION 27. Section 10 and section 87 of chapter 182 of the acts of 2008 is hereby repealed.

SECTION 28. Notwithstanding any general or special law to the contrary, on or before October 1, 2008, the comptroller shall transfer $15,000,000 from the Medical Security Trust Fund established under section 14G of chapter 151A to the Health Information Technology Fund established in section 6E of chapter 40J.

SECTION 29. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts shall expand the entering class at its medical school and increase residencies for medical school graduates for students committed to entering the primary care field and to working in underserved regions of the commonwealth. The trustees shall develop a master plan for expanding medical student enrollment and increasing internships and residencies for medical school graduates who are committed to primary care and work in underserved regions without reducing academic quality, together with a financial plan to support such expansion, and shall report that plan to the joint committee on health care financing and the house and senate committees on ways and means on or before January 1, 2009.

SECTION 30. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts, in conjunction with the state health education center at the University of Massachusetts Medical Center, shall establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the University of Massachusetts Medical School. In exchange for said waivers of tuition and fees, the contract shall require at least 4 years of service within the commonwealth in areas of primary care, public or community service or underserved areas, as determined by the health care workforce center established under section 25L of chapter 111 and the learning contract committee, in coordination with the area health education center and

state and regional health planning agencies. If a student fails to perform said service as required by an enhanced learning contract, that student shall pay the difference between the tuition paid and double the amount of the tuition charged together with an origination fee, interest per annum at prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment fee as established by the board. No service or tuition loan repayment shall be required prior to the termination of any internship and residency requirements. Interest shall begin to accrue upon completion of the requirements for the degree. The commonwealth shall bear the cost of such tuition and fee waivers for enhanced learning contracts. The dean of the medical school shall report annually the number of students participating in enhanced learning contracts, the area of medicine within which payback is to be performed and the number of students utilizing the repayment option. The report shall also outline the effects of payback in the underserved areas of the commonwealth.

SECTION 31. (a) Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth a separate fund to be known as the Massachusetts Nursing and Allied Health Workforce Development Trust Fund to which shall be credited any appropriations, bond proceeds or other monies authorized by the general court and specifically designated to be credited thereto, and additional funds, including federal grants or loans or private donations made available to the commissioner of higher education for this purpose. The department of higher education shall hold the fund in an account separate and apart from other funds or accounts. Amounts credited to the fund shall be expended by the commissioner of higher education to carry out subsection (b). Any balance in the fund at the close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not revert to the General Fund.

(b) The Massachusetts Nursing and Allied Health Workforce Development Trust Fund shall be used to develop and support, in consultation with the Massachusetts Nursing and Allied Health Workforce Development Advisory Committee, short-term and long-term strategies to increase the number of public and private higher education faculty and students who participate in programs that support careers in fields related to nursing and allied health. The commissioner of higher education may expend such funds as may be necessary for the administration of the Massachusetts Nursing and Allied Health

Workforce Development Initiative. In furtherance of these public purposes, the commissioner of higher education shall expend funds in the fund for activities that are calculated to increase the number of qualified nursing and allied health faculty and students and improve the nursing and allied health educational offerings available in public higher education institutions. Grants and other disbursements and activities may involve, without limitation, the University of Massachusetts, state and community colleges, private institutions of higher education institutions in partnership with public institutions of higher education, business and industry partnerships, regional alliances, workforce investment boards, organizations granted tax-exempt status under section 501(c)(3) of the Internal Revenue Code and other community groups which promote the nursing profession. Grants and other disbursements and activities may support, without limitation: (i) the goal of rapidly increasing the number of nurses and allied health workers; (ii) enhancing the role of the system of public and private higher education, as institutions and in partnerships with other stakeholders, in meeting the short-term and long-term workforce challenges in the nursing and allied health professions; (iii) the development and use of innovative curricula, courses, programs and modes of delivering education in nursing and allied health professions for faculty and students in these fields; (iv) activities with the growing network of stakeholders in the nursing and allied health professions to create, implement, share and make broadly and publicly available best practices and innovative programs relative to instruction, development of partnerships and expanding and maintaining faculty and student involvement in careers in these fields; and (v) strengthening the institutional capacity to develop and implement long-term programs and policies to effectively respond to these challenges.

SECTION 32. Notwithstanding any general or special law to the contrary, the department of housing and community development, in consultation with the executive office of health and human services, the department of workforce development and the Massachusetts housing finance agency, shall establish a pilot grant or loan program to assist hospitals, community health centers, and physician practices in providing housing grants or loans for health care professionals who commit to practicing in underserved areas, identified by the health care workforce center, established under section 25L of chapter 111, and who meet income eligibility guidelines established by the department. Grants and loans may be used for: (i) purchasing a principal residence, including

cooperative housing, that falls within price guidelines established by the department, including costs for down payments, mortgage interest rate buy-downs, closing costs and other costs determined to be eligible by the department; and (ii) payments for security deposits and advance payments for rental housing. The department, to the extent possible shall seek matching funds from hospitals and other private entities.

The department shall promulgate rules and regulations for the administration and enforcement of this section including, establishing provisions for eligibility, specifying the expenses for which grants and loans may be made, and determining the procedures necessary to qualify for assistance.

Two years after the commencement of the pilot program, the department shall report to the house and senate committees on ways and means, the joint committee on housing and the joint committee on health care financing, the results of the pilot program and shall recommend it for expansion, continuation or discontinuation.

SECTION 33. Notwithstanding any general or special law to the contrary, the MassHealth payment policy advisory board, established in section 16M of chapter 6A of the General Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for primary care physicians, nurse practitioners and subspecialists who provide primary care services, such as preventive care, certain evaluation and management procedures, early periodic screening, diagnosis and treatment and scheduled weekend and holiday services, in order to focus on prevention and wellness and delivery of primary care to identify illness earlier, to better manage chronic disease and to avoid costs associated with emergency room visits and hospitalizations. The committee shall report its findings, including recommendations for the amount of funding and the sources of funding, to the joint committee on health care financing, and the house and senate committees on ways and means not later than January 1, 2009.

SECTION 34. Notwithstanding any general or special law to the contrary, no later than October 1, 2012, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement computerized physician order entry systems as defined by the department. The systems shall be certified by the Certification Commission for Healthcare Information Technology or a successor

agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 35. Notwithstanding any general or special law to the contrary, no later than October 1, 2015, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement interoperable electronic health records systems, as defined by the department. The system shall be certified by the Certification Commission for Healthcare Information Technology or a successor agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 36. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall maximize enrollment of eligible persons in the MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly, the Enhanced Community Options Program and the Community Choices program, or comparable successor programs, and shall develop dual eligible plans. For the purposes of this section, "dual eligible plans" shall be plans that offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65.

No later than January 1, 2009, the executive office of health and human services shall prepare a report identifying clinical, administrative and financial barriers to the expansion of dual eligible plans, and shall recommend steps to remove the barriers and implement the plans. The executive office shall also explore the feasibility of developing a process to passively enroll any eligible beneficiary who has not voluntarily enrolled in an approved program. Before finalizing the report, the executive office shall hold a public consultative session that shall include organizations representing seniors, organizations representing disabled persons, organizations representing health care consumers, organizations representing racial and ethnic minorities, health delivery systems and health care providers. The report shall include consideration of changes in procurement standards and MassHealth payment methodologies to promote enrollment in dual eligible plans. The report shall include estimates of the costs and benefits of implementing steps to remove barriers to expanded enrollment in dual eligible plans, including financial savings and improved quality of care.

The report shall be provided to the committee on health care financing and the house and senate committees on ways and means. Subject to appropriation, the executive office of health and human services shall implement any steps recommended by the report. Not later than 1 year after the filing of the report, the executive office shall issue a progress statement on expanded enrollment in dual eligible plans.

SECTION 37. Notwithstanding any general or special law to the contrary, the division of insurance shall conduct an investigation and study of the costs of medical malpractice coverage for health care providers, as defined in section 193U of chapter 175 of the General Laws. The investigation and study shall include, but not be limited to, an examination and analysis of the following: (1) the availability and affordability of medical malpractice insurance; (2) the factors considered by medical malpractice insurers when increasing premiums; (3) options for decreasing premiums including, but not limited to, establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties for which the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance and prorating premiums for providers who practice less than full-time; and (4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study which may include, but shall not be limited to, charges borne by the health care industry or other entities. The division shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The division shall report its findings and recommendations to the house and senate committee on ways and means and the joint committee on health care financing not later than January 1, 2009.

SECTION 38. Notwithstanding any general or special law to the contrary, no later than January 1, 2009, the executive office of health and human services, in consultation with the commission on end–of-life care established by section 480 of chapter 159 of the Acts of 2000, shall initiate a public awareness campaign to highlight the importance of end-of-life care planning. The campaign shall include, but not be limited to, dissemination of information and other activities that educate the public

about existing options for care at the end of life and how to communicate their end-of-life care wishes to family members and health care providers.

SECTION 39. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the commission on end-of-life care established by section 480 of chapter 159 of the Acts of 2000, shall establish a pilot program to test the implementation of the physician order for life-sustaining treatment paradigm program to assist individuals in communicating end-of-life care directives across care settings in at least 1 region of the commonwealth. The pilot program shall include educational outreach to patients, families, caregivers and health care providers regarding the physician order for life-sustaining treatment paradigm program. The executive office of health and human services, in conjunction with the end-of-life commission, shall develop measures to test the success of the pilot program and make recommendations for the establishment of a state-wide program.

SECTION 40. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the health care quality and cost council, commission on end-of-life care established by section 480 of chapter 159 of the Acts of 2000, and the Betsy Lehman Center for Patient Safety and the Reduction of Medical Errors, shall convene an expert panel on end-of-life care for patients with serious chronic illnesses. The panel shall investigate and study health care delivery for these patients and the variations in delivery of such care among health care providers in the commonwealth. For the purposes of this investigation and study, "health care providers" shall mean facilities and health care professionals licensed to provide acute inpatient hospital care, outpatient services, skilled nursing, rehabilitation and long-term hospital care, home health care and hospice services. The panel shall identify best practices for end-of-life care, including those that minimize disparities in care delivery and variations in practice or spending among geographic regions and hospitals, and shall present recommendations for any legislative, regulatory, or other policy changes necessary to implement its recommendations.

SECTION 41. Notwithstanding any general or special law to the contrary, the secretary of administration and finance and the secretary of

health and human services shall prepare and submit a report to the general court about the allocation for and use of state funds by acute care hospitals, non-acute care hospitals, Medicaid managed care organizations, other managed care organizations, community health centers and carriers contracting with the commonwealth health insurance connector authority. The report shall include: (1) a comprehensive review of the current manner, amount and purposes of annual state funding received by those entities, including a description of the source of the funding; (2) an assessment of the change in total state funding for those entities over the past 5 years, with particular attention paid to the impact of chapter 58 of the acts of 2006; (3) an assessment of how those entities use state funds; (4) an assessment of whether the current payment structure assures the delivery of quality health care in the most cost-effective way; (5) an analysis of financial and management practices of those entities by benchmarking performance with respect to quality and cost effectiveness against national performance levels and similar health care providers in the commonwealth; (6) identification of common factors that may contribute to the fiscal instability of those entities; (7) recommendations for the development of performance and operational benchmarks; (8) recommendations for ensuring that the entities are spending state and other funds in a fiscally-responsible manner and providing quality care; (9) recommendations for legislative and other action necessary to strengthen state oversight and ensure greater accountability of state resources; (10) an assessment of the manner in which hospitals seek payment from consumers, including an analysis of the impact that court filing fees have on their ability to collect payment; and (11) recommendations for regulations regarding the due diligence that facilities shall exercise in seeking to collect payment from consumers before seeking reimbursement from the commonwealth.

SECTION 42. (a) Notwithstanding any general or special law to the contrary, there shall be a special commission on the health care payment system that shall investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.

(b) The commission shall consist of the secretary of administration and finance and the commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, and 5 members to be

appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and 1 of whom shall be a health economist or expert in the area of payment methodology.

The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. No action of the commission shall be considered official unless approved by a majority vote of the commission.

(c) The commission (i) shall examine payment methodologies and purchasing strategies, including, but not limited to, alternatives to fee-for-service models such as blended capitation rates, episodes-of-care payments, medical home models, and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies, (ii) recommend a common transparent payment methodology that promotes coordination of care and chronic disease management; rewards primary care physicians for improving health outcomes; reduces waste and duplication in clinical care; decreases unnecessary hospitalizations and use of ancillary services; and provides appropriate reimbursement for investment in health information technology that reduces medical errors and enables coordination of care, and (iii) recommend a plan for the implementation of the common payment methodology across all public and private payers in the commonwealth, including a plan under which the commonwealth shall seek a waiver from federal Medicare rules to facilitate the implementation of the common payment system.

(d) In making its investigation, the commission shall consult with the health care quality and cost council, the division of health care finance and policy, health care economists, and others individuals or organizations with expertise in state and federal health care payment methodologies and reforms. The commission shall use data and recommendations gathered in the course of these consultations as a basis for its findings and recommendations.

(e) The commission shall file a report of its findings and recommendations, including any proposed legislation needed to implement the recommendations.

Before a final vote on any recommendations, the commission shall consult with a reasonable variety of parties likely to be affected by its recommendations, including, but not limited to, the office of Medicaid, the division of health care finance and policy, the commonwealth health insurance connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers.

The commission shall hold its first meeting no later than September 15, 2008 and shall file the report of its findings and recommendations together with legislation, if any, with the clerks of the senate and the house of representatives and with the governor no later than April 1, 2009.

SECTION 43. Notwithstanding any general or special law to the contrary, the secretary of health and human services, in consultation with the health care quality and cost council, shall: (i) examine the feasibility of the commonwealth entering into an interstate compact with 1 or more states to establish an independent entity to research the comparative effectiveness of medical procedures, drugs, devices, and biologics, so that research results can be used as a basis for health care purchasing and payment decisions, and (ii) make recommendations concerning the entity's design. The secretary shall consider existing state and country models, including, but not limited to, the Washington State Health Care Authority's Health Technology Assessment program, the National Institute for Health and Clinical Excellence in Britain, and the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen in Germany. The secretary shall file a report with the results of the study together with legislation, if any, with the clerk of the senate and the clerk of the house of representatives no later than March 30, 2009.

SECTION 44. Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall restructure its payment system to support primary care practices that use a medical home model

and shall develop a program to support primary care providers in developing an organizational structure necessary to provide a medical home. The office of Medicaid shall work with Medicaid managed care organizations to develop and implement the program.

The office shall consider payment methodologies that support care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. Payment shall reward quality and improved patient outcomes.

The office shall identify practices, for participation in the program, that provide care to its patients using a medical home model, which at minimum shall include primary care practices with a multi-specialty team that provides patient-centered care coordination through the use of health information technology and chronic disease registries, across the patient's life-span and across all domains of the health care system and the patient's community.

The office shall promulgate regulations for the phase-in and implementation of this restructured primary care payment system.

The office, subject to appropriation and in coordination with the health care workforce center and the Massachusetts Academy of Family Physicians, shall develop a program to provide support to practices interested in developing an organizational structure necessary to provide a medical home.

The office shall conduct an annual program evaluation including documentation of cost savings achieved through implementation; health care screening rates, outcomes and hospitalization rates for patients with chronic illnesses such as pediatric asthma, diabetes, heart disease, hospitalization and readmission rates for the frail elderly. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

SECTION 45. Notwithstanding any general or special law to the contrary, the first report of health care workforce center required by section 25L of chapter 111 shall be filed no later than December 31, 2009 and shall focus on the primary care workforce, defined as physicians with a medical specialty in family medicine, internal

medicine, pediatrics, or obstetrics/gynecology or nurse practitioners practicing as primary care providers.

SECTION 46. Notwithstanding any general or special law to the contrary, the department of public health shall, no later than January 1, 2009, establish a registry of exemptions granted by the department pursuant to section 6 of chapter 350 of the acts of 1993 to persons who filed a notice of intent to acquire medical, diagnostic, or therapeutic equipment used to provide an innovative service or which is a new technology, as defined in section 25B of chapter 111 of the General Laws. Registered exemptions shall be non-transferable. After January 1, 2009, all such exemptions that have not been registered shall be void. Exemptions granted by the department pursuant to said section 6 of said chapter 350 of the acts of 1993, but for which the equipment has not been placed in regular service, shall expire on January 1, 2010.

SECTION 47. Notwithstanding any general or special law to the contrary, any entity providing ambulatory surgical center services which is in operation or under construction, as determined by the department of public health, on the effective date of this act shall be exempt from the determination of need requirement of section 53G of chapter 111 of the General Laws and shall be eligible, pursuant to said section 53G of said chapter 111, to make applications to the department for a clinic license for up to 6 months after the effective date of regulations adopted by the department pursuant to said section 53G of said chapter 111.

SECTION 48. Notwithstanding any general or special law to the contrary, the department of public health shall promulgate regulations necessary to implement, administration and enforcement of section 4N of chapter 111 of the General Laws in accordance with chapter 30A no later than October 1, 2008, and shall begin implementation of the outreach and education program established under said section 4N no later than January 1, 2009.

SECTION 49. Notwithstanding any general or special law to the contrary, the bureau of managed care within the division of insurance shall convene the first advisory committee required under section 5B of chapter 176O of the General Laws no later than January 1, 2009.

SECTION 50. Notwithstanding any general or special law to the contrary, no later than July 31, 2012, the health information technology oversight council established by section 6D of chapter 40J, shall submit a report to the joint committee on health care financing and the senate and house committees on ways and means on the status of health information technology in the commonwealth. The report shall include the status of: (i) the implementation and use of electronic health records systems, such as rate of provider participation; (ii) the statewide interoperable electronic health records network and its capacity to exchange health information between and among components of the health system, with special focus on ambulatory care providers; (iii) the security and privacy of health information technology developed and disseminated through activities of the council; and (iv) the impact of health information technology on health care quality, health outcomes of patients, and health care costs.

SECTION 51. Notwithstanding any general or special law to the contrary, the health information technology oversight council established by section 6D of chapter 40J, shall have as its goal full implementation of electronic health records systems and the statewide interoperable electronic health records network by January 1, 2015.

SECTION 52. Subsection (d) of section 55 of chapter 118E, as appearing in section 16, shall take effect on January 1, 2011.

SECTION 53. Subsection (d) of section 5A of chapter 176O of the General Laws, as appearing in section 24, shall take effect on January 1, 2011.

SECTION 54. Sections 17 and 25 shall take effect on January 1, 2012.

SECTION 55. Section 8 shall take effect on October 1, 2012.

SECTION 56. Sections 10, 11, 13 and 23 shall take effect on October 1, 2015.”.